



# MONTHLY REIMBURSEMENT CLAIM FOR TITLE IV-D EXPENDITURES

State Form 24220 (R5 / 12-99) / FM 0920

Financial Management  
Family and Social Services Administration  
402 West Washington St., P.O. Box 7128  
Indianapolis, Indiana 46207-7128

**INSTRUCTIONS:** Submit completed form with State Form 24221/FM 0919 (on reverse) to Financial Management at the address listed above by the 10th of the month.

Month / Year	County	Agency (check one) <input type="checkbox"/> Prosecutor <input type="checkbox"/> Clerk <input type="checkbox"/> IV-D Court
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1. PERSONAL SERVICES			
101	SALARIES AND WAGES		\$
102	EMPLOYEE BENEFITS TOTAL		\$
102A	SOCIAL SECURITY		
102B	RETIREMENT		
102C	INSURANCE		
102D	UNEMPLOYMENT		
102E	OTHER (specify)		
TOTAL PERSONAL SERVICES			\$
2. SUPPLIES			
201	OFFICE SUPPLIES		
202	OTHER		
TOTAL SUPPLIES			\$
3. OTHER SERVICES AND CHARGES			
301	POSTAGE		
302	TRAVEL (Attach copy of Travel Voucher)		
303	TELEPHONE		
304	PRINTING		
305	LEGAL NOTICE		
306	COPY SERVICES		
307	MAINTENANCE OF EQUIPMENT		
308	BONDS AND INSURANCE		
309	RENT		
310	UTILITIES		
311	DUES AND SUBSCRIPTIONS		
312	DATA PROCESSING CHARGES		
313	EQUIPMENT RENTAL		
314	OTHER (specify)		
TOTAL OTHER SERVICES AND CHARGES			\$
4. CAPITAL OUTLAYS (Attach FM 0910)			
401	FURNITURE AND FIXTURES		
402	OFFICE MACHINES		
403	OTHER (specify)		
TOTAL CAPITAL OUTLAYS			\$
*** GRAND TOTAL OF ALL EXPENDITURES			\$
5. PROGRAM INCOME			
	INTEREST EARNED (Title IV-D cases only)		\$
*** NET TOTAL EXPENDITURES (Grand Total Expenditures Minus Interest Earned)			\$
CERTIFICATION			
I certify that the expenditures as specified above together with the reported program income is a true and accurate account of the program income and lawful expenditures authorized by the Child Support Bureau during the above described month.			
Signature of Authorized Official		Person preparing the claim	Telephone
			Date
FOR FM USE ONLY:			
Reimbursement at 100% \$		Balance \$	
Comments:		Reimbursement paid at FFP rate \$	
Paid: \$		Total reimbursement \$	